DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 2003 — 18

2. STATE: Florida

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447

7. FEDERAL BUDGET IMPACT:
a. FFY 2003 $ (4,159)
b. FFY 2004 $ (16,463)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-D Part I
Version 25

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-D Part I
Version 24

10. SUBJECT OF AMENDMENT:
Nursing Home Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
comments will be forwarded when received

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bob Sharpe

13. TYPED NAME:
Mr. Bob Sharpe

14. TITLE:
Deputy Secretary for Medicaid

15. DATE SUBMITTED: 7/30/03

16. RETURN TO:
Mr. Bob Sharpe
Deputy Secretary for Medicaid
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop #20
Tallahassee, FL 32308

ATTN: Kay Newman

FORM HCFA-179 (07-92)

Instructions on Back

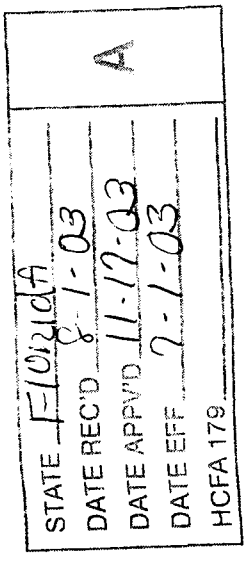
FLORIDA TITLE XIX LONG-TERM CARE REIMBURSEMENT PLAN

VERSION XXV EFFECTIVE DATE: _____

I. Cost Finding and Cost Reporting

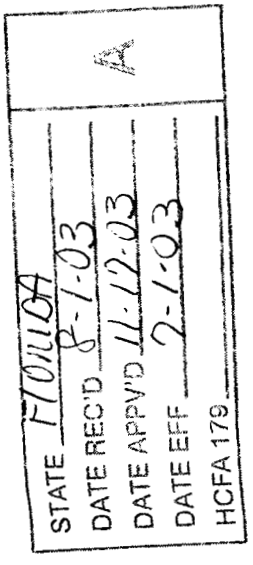
A. Each provider participating in the Florida Medicaid nursing home program shall submit a uniform cost report and related documents required by this plan using Agency for Health Care Administration (AHCA) form AHCA 5100-000, Rev. 7-1-90, as revised and prepared in accordance with the related instructions, postmarked or accepted by a common carrier no later than 3 calendar months after the close of its cost reporting year. Upon written request, AHCA shall grant an extension of time for filing cost reports. Four complete, legible copies of the cost report shall be submitted to AHCA, Bureau of Medicaid Program Analysis, Audit Services.

B. All providers are required to detail all of their costs for their entire reporting period, making appropriate adjustments as required by this plan for determination of allowable costs. For a new provider with no cost history in a newly constructed or existing facility entering the program or an existing provider in a newly constructed replacement facility, the interim operating and patient care cost per diems shall be the lesser of: the class reimbursement ceiling based on Section V of this Plan, the budgeted operating and patient care cost per diems approved by AHCA based on Section III of this plan, or the average operating and patient care per diems (excluding incentives) in the district in which the facility is located plus 50% of the difference between the average district per diem (excluding incentives) and the facility class ceiling. Existing providers in a newly constructed replacement facility shall receive the greater of the above operating and patient care cost per diems or their current operating and patient care per diems that are in effect prior to the operation of their replacement facility, not to exceed the facility class ceilings. The average district per diem is calculated by taking the sum of all operating and patient care per diems divided by the number of facilities. Changes



of ownership or of licensed operator do not qualify for increases in reimbursement rates associated with the change of ownership or of licensed operator. The Agency will provide that the initial nursing home reimbursement rates, for the operating, patient care, and MAR components, associated with related and unrelated party changes of ownership or licensed operator filed on or after September 1, 2001, are equivalent to the previous provider's reimbursement rate.

For a new provider with no cost history resulting from a change of ownership or operator, filed prior to September 1, 2001, where the previous provider participated in the Medicaid program, the interim operating and patient care per diems shall be the lesser of: the class reimbursement ceiling based on Section V of this Plan, the budgeted per diems approved by AHCA based on Section III of this Plan, or the previous providers' operating and patient care cost per diem (excluding incentives), plus 50% of the difference between the previous providers' per diem (excluding incentives) and the class ceiling. For a new provider with no cost history resulting from a change of ownership or operator filed on or after September 1, 2001, where the previous provider participated in the Medicaid program, the interim operating and patient care new provider ceilings shall be equivalent to the rates being paid to the previous provider for operating and patient care costs (excluding incentives). The above new provider ceilings, based on the district average per diem or the previous providers' per diem, shall apply to all new providers with a Medicaid certification effective on or after July 1, 1991. The new provider reimbursement limitation above, based on the district average per diem or the previous providers' per diem, which affects providers already in the Medicaid program, shall not apply to these same providers beginning with the rate semester in which the target reimbursement provision in Section V.B.16. of this plan does not apply. This new provider reimbursement limitation shall apply to new



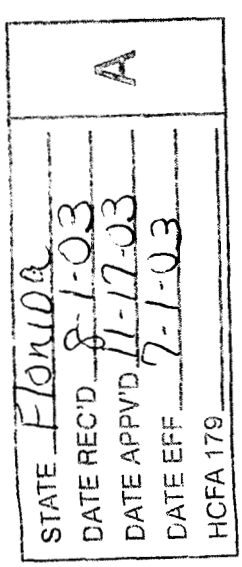
providers entering the Medicaid program, even if the new provider enters the program during a rate semester in which Section V.B.16. of this plan does not apply. New provider ceilings applicable to the first rate semester a new provider enters the program shall be the basis for calculating subsequent rate semester new provider target ceilings for that same provider through the following calculation:

Effective July 1, 1996, except for: the January 1, 2000 and the January 1, 2002 rate semesters for the patient care component and the July 1, 2002 and July 1, 2003 rate semesters for the operating component, establish the target reimbursement for operating and patient care cost per diems for each provider by multiplying each provider's target reimbursement rate for operating and patient care cost in Step V.B.16. from the previous rate semester, excluding incentives and the Medicaid Adjustment Rate (MAR) with the quantity:

$$1 + 1.4 \times \left(\frac{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the prospective rate period}}{\text{Florida Nursing Home Cost Inflation Index at the midpoint of the current rate period}} - 1 \right)$$

In the above calculation, the 1.4 shall be referred to as the inflation multiplier.

New providers limited by this section for the patient care component for the January 1, 2000 rate semester and the operating component for the July 1, 2002 and July 1, 2003 rate semester only shall be entitled to a similar adjustment in the inflation multiplier as described in Section V. B.16. For the January 1, 2002 rate semester, the direct and indirect subcomponents of the patient care per diem shall not be subject to the target reimbursement described above. For rate semesters subsequent to January 1, 2002, the indirect patient care subcomponent shall be limited to the target reimbursement described above, whereas the direct patient care subcomponent shall not be limited to the target reimbursement described above.



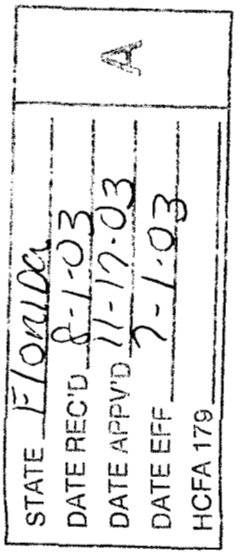
Providers on budget at December 31, 2001 shall have their interim patient care cost split into direct and indirect subcomponents based on a 65% and 35% split, respectively, for the January 1, 2002 rate semester. Upon submission of an initial cost report, the actual allocation of direct and indirect patient care costs will be adjusted through the cost settlement process.

New providers with no cost history resulting from a change of ownership or operator filed on or after September 1, 2001, where the previous provider participated in the Medicaid program, shall be eligible for the Medicaid Adjustment Rate (MAR). The interim MAR shall be equivalent to the prior providers' MAR. For new providers who enter the program operating a facility that had been previously operated by a Medicaid provider, the property reimbursement rate shall be established per Section V.E.4. of this plan. The property cost per diem for newly constructed facilities or replacement facilities shall be the lesser of: the budgeted fair rental value rate approved by AHCA based on Section V.E. of this plan; or the applicable fair rental value based upon the cost per bed standard that was in effect 6 months prior to the date the facility was first put in service as a nursing home. Return on equity or use allowance per diems shall be the budgeted rate approved by AHCA per Section III of this plan. Prospective reimbursement rates shall only be set on cost reports for periods of 6 months or more but not morethan 18 months. Cost reporting periods ending on or after July 1, 1991, shall be for periods 6 months or more but not more than 18 months. Interim rates shall be cost settled for the interim rate period, and the cost settlement is subject to the above new provider reimbursement limitations. For changes of ownership or licensed operator filed on or after September 1, 2001 the provider will be required to file an initial cost report. For cost settlements related to changes of ownership or licensed operator filed on or after September 1, 2001, the new provider's operating target, patient care target, and MAR

rates will be limited to the operating, patient care, and MAR rates that were being paid to the previous provider.

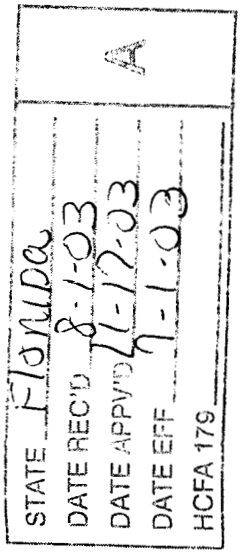
C. The cost report shall be prepared by a Certified Public Accountant in accordance with Chapter 409.908, Florida Statutes, on the form prescribed in Section I.A., and on the accrual basis of accounting in accordance with generally accepted accounting principles as established by the American Institute of Certified Public Accountants (AICPA) as incorporated by reference in Rule 61H1-20.007, F.A.C., the methods of reimbursement in accordance with Medicare (Title XVIII) Principles of Reimbursement, the Provider Reimbursement Manual (CMS-PUB.15-1) (1993) incorporated herein by reference except as modified by the Florida Title XIX Long Term Care Reimbursement Plan and State of Florida Administrative Rules. For governmental facilities operating on a cash method of accounting, data based on such a method of accounting shall be acceptable. The CPA preparing the cost report shall sign the cost report as the preparer, or, in a separate letter, state the scope of his work and opinion in conformity with generally accepted auditing standards as incorporated by reference in Rule 61H1-20.008, F.A.C., and AICPA statements on auditing standards. Cost reports, which are not signed by a Certified Public Accountant, or are not accompanied by a separate letter signed by a CPA, shall not be accepted.

D. Effective for January 1, 2002 rate setting, providers with a fiscal year ending on or before March 31, 2001, may elect, without prior approval from the Agency for Health Care Administration, to change their current fiscal year end and file a new cost report for a period of not less than six months. Should a provider elect to change their current fiscal year end and file a new cost report, then cost reports filed for the next two years must have the same year end.



E. All prior year cost reports must be submitted to and accepted by the Agency, before the current year cost report may be accepted for rate setting. If a provider submits a cost report late, after 3 calendar months, and that cost report would have been used to set a lower reimbursement rate for a rate semester had it been submitted within 3 calendar months, then the providers' rate for that rate semester shall be retroactively calculated using the new cost report, and full payments at the recalculated rate shall be effected retroactively. The lower rate shall not be paid retroactively if the provider adequately demonstrates, through documentation, that emergency circumstances prevented the provider from submitting the cost report within the prescribed deadline. Similarly, if a provider submits a cost report late because of emergency circumstances, and the use of that cost report would have resulted in higher reimbursement for a rate semester had it been submitted within 3 calendar months, then the provider's rate for that rate semester shall be retroactively calculated using the new cost report, and full payment at the recalculated rate shall be effected retroactively. Emergency circumstances are limited to loss of records from fire, flood, theft or wind.

F. A provider which voluntarily or involuntarily ceases to participate in the Florida Medicaid Program or experiences a change of ownership shall file a final cost report in accordance with Section 2414.2, CMS-PUB.15-1 (1993) when that provider has been receiving an interim reimbursement rate. All providers are required to maintain financial and statistical records in accordance with 42 CFR 413.24 (2000), sections (a), (b), (c), and (e). The cost report is to be based on financial and statistical records maintained by the facility. Cost information shall be current, accurate, and in sufficient detail to support costs set forth in the report. This includes all ledgers, books, records, original evidence of cost and other records in accordance with CMS PUB. 15-1 (993) which pertain to the determination of reasonable costs, and shall be capable of and available for



auditing by State and Federal authorities. All accounting and other records shall be brought up to date at the end of each fiscal quarter. These records shall be retained by the provider for a minimum of 5 years following the date of submission of the cost report form to AHCA.

G. Records of related organizations as identified by 42 CFR 413.17 (2000) shall be available upon demand to representatives, employees, or contractors of AHCA, the Auditor General, General Accounting Office (GAO), or Department of Health and Human Services (HHS).

H. AHCA shall retain all uniform cost reports submitted for a period of at least 3 years following the date of submission of such reports and shall maintain those reports pursuant to the record-keeping requirements of 42 CFR 431.17 (2000). Access to submitted cost reports shall be in conformity with Chapter 119, Florida Statutes.

I. Chart of Accounts: For cost reports filed for the cost reporting periods ending on or after December 31, 2002, all providers must use the standard chart of accounts (AHCA Form Number 5300-0001 AUG 02) to govern the content and manner of the presentation of financial information to be submitted by Medicaid long-term care providers in their cost reports. The standard chart of accounts includes specific accounts for each component of direct care staff by type of personnel and may not be revised without the written consent of the Auditor General.

II. Audits and Desk Reviews

Cost reports submitted by providers of nursing home care in accordance with this Plan are subject to an audit or desk review on a random basis and at any time the agency has been informed or has reason to believe that a provider has claimed or is claiming reimbursement for unallowable costs. The performance of a desk review does not preclude the performance of an audit at a later date.

A. Description of AHCA's Procedures for Audits-General

1. Primary responsibility for the audit of providers shall be borne by AHCA. The efforts of AHCA audit staff may be augmented by contracts with CPA firms to ensure that the requirements of 42 CFR 447.202 (2000) will be met.
2. All audits shall be based on generally accepted auditing standards as incorporated by reference in Rule 61H1-20.008, F.A.C., of the AICPA.
3. Upon completion of each audit, the auditors shall issue a report which meets the requirements of 42 CFR 447.202 (2000) and generally accepted auditing standards as incorporated by reference in Rule 61H1- 20.008, F.A.C. The Auditor shall declare an opinion as to whether, in all material respects, the financial and statistical report submitted complies with all Federal and State regulations pertaining to the reimbursement program for long-term care facilities. All reports shall be retained by AHCA for 3 years.
4. The provider's copy of the audit report shall include all audit adjustments and changes and the authority for each, and all audit findings and shall be accompanied by such other documentation as is necessary to clarify such adjustments or findings.

B. Field Audit and Desk Review Procedures upon receipt of a cost report from the provider prepared in accordance with instructions furnished by the agency, the agency will determine whether an audit or desk review is to be performed. Providers selected for audit or desk review will be notified in writing by the AHCA Audit Office or CPA firm assigned to perform the audit or desk review.

1. Upon completion of an audit or desk review and before publication of the audit of desk review report, the provider shall be given an exit conference at which all findings will be discussed and explained. A copy of the proposed audit or desk review adjustments will be given to the provider at least ten (10) days

before the exit conference. If the provider fails to schedule an exit conference within twenty calendar days of receipt of the adjustments, the audit or desk review report will be issued without an exit conference. Desk review exit conferences will be conducted through the mail or in the agency's office in Tallahassee.

2. Following the exit conference, the provider has sixty (60) calendar days to submit documentation or other evidence to contest any disallowed expenditures or other adjustments. For adjustments made due to lack of adequate documentation or lack of support, any documentation received after the sixty-day period shall not be considered when revising adjustments made due to lack of adequate documentation or lack of support. However, the sixty-day limitation shall not apply if the provider can adequately demonstrate, through documentation, that emergency circumstances prevented the provider from submitting additional documentation within the prescribed deadline. Emergency circumstances are limited to loss of records from fire, wind, flood or theft.

3. All audit or desk review reports shall be issued by certified mail, return receipt requested and shall be mailed to the address of the nursing home to the attention of the administrator. The provider shall have twenty-one (21) calendar days from the date of receipt of the audit report to challenge any audit or desk review adjustment or audit or desk review finding contained in the report by requesting an administrative hearing in accordance with Section 120.57, Florida Statutes and Chapter 28.106, Florida Administrative Code. The audit or desk review report shall constitute prima facie evidence of the propriety of the adjustments contained therein. The burden of proof is upon the provider to affirmatively demonstrate the entitlement to the Medicaid reimbursement. Except as